be undertaken only for obstructive calculus pyonephrosis, tumor, or other lesion incompatible with life and health.

PYELOPLASTY IN HORSESHOE KIDNEY

Ideally speaking, repair of the hydronephrotic pelvis often found in fused kidney should be the operation of choice to restore normal drainage and prevent infection and recurrent calculosis. The frequent high insertion of the ureter in an anterior position lends itself to re-implantation to a more normal posterior position at a lower level and, according to Atherton,[2] should be tried in suitable cases. To the author's knowledge there are no reports of results of this operation except one by McGinn and Wickham.[11] In this case the upper right ureter was injured during transperitoneal heminephrectomy for a Wilm's tumor in a child two years old. Six days later the ureter was re-implanted into the right pelvis and nephrostomy performed. Death occurred two months later from uremia and overwhelming pyelonephritis due to stasis, but in the interim the patient presented a normal health status.

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The Relation of the Private Physician to the Cancer Control Program

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THE private physician in California is officially represented in the cancer control program by the Cancer Commission of the California Medical Association. The Commission was organized by the C.M.A. House of Delegates in 1931 for the purpose of professional education in the diagnosis and treatment of cancer and for increasing cancer facilities in this state. In June, 1945, the C.M.A. Council directed the Commission to cooperate with and participate in the work of the American Cancer Society and to cooperate with public health agencies.

The Cancer Commission has made material progress in its objectives although its work was interrupted during the war years. During the past two years the pioneer Cancer Manual, known as "Cancer Commission Studies," has been revised and publication of chapters began in the May, 1947, number of CALIFORNIA MEDICINE. After publication in serial form the chapters will be bound for a reference manual and will be distributed to the members of the California Medical Association.

The Cancer Commission has established a speakers' panel of more than 100 of the outstanding physicians in California. Speakers on this panel are available to any county medical society in the state to address meetings or for Cancer Clinic days. The Commission has secured the cooperation of the medical schools in Los Angeles and San Francisco in giving refresher courses in cancer to practicing physicians. These refresher courses will be repeated at appropriate intervals and will be available to all members of the California Medical Association.

In the field of cancer facilities the Commission has encouraged the establishment of Consultative Tumor Boards wherever practical in approved general hospitals. The number of Tumor Boards has increased from 20 to 40 during the past year and at least ten other hospital staffs are considering the

establishment of Tumor Boards. The Commission has prepared for publication *Minimum Standards* for Tumor Boards and for Cancer Detection Centers to stimulate and develop these facilities in this state.

During the past two years the Cancer Commission has had the opportunity of working with the American Cancer Society in developing a new state organization and in preparing a policy for the hospitalization of needy cancer patients. During the past year the Commission has cooperated with the State Department of Public Health in assisting the Los Angeles County Medical Society to make a cancer survey. The Commission plans to continue these surveys throughout the state with the cooperation of the Department of Public Health and county medical societies.

The Cancer Commission is more than ever convinced that cancer control is fundamentally the problem of the private physician. As it was well expressed by the American College of Radiology, "The success or failure of any cancer control program is going to depend in a large measure upon the skill, knowledge, and attitude of the attending physician or family doctor." The great majority of cancer patients will first be seen by the family physician and the fate of these patients is primarily in his hands. Whether or not he insists on the immediate diagnosis and whether or not he obtains for his patient prompt and adequate treatment will determine the cure of a large percentage of cancer patients.

The effective program of popular health education by the American Cancer Society and Public Health agencies is bringing an increasing number of cancer patients to physicians while the disease is in the early stage and curable. The recognition and management of these early cases make the private physician the key factor in cancer control.

There is no longer any question that a large percentage of early cancer is curable. (See Table 1.)

TABLE 1.—*Early Cases—Five Year Cures*

Breast—no nodes involved	60-75%	Cheevers
Cervix—Groups I and II*	58%	Healy
Fundus of Uterus	75%	Corscaden
Testicle	42%	Pendergrass
Colon—no nodes	63%	Rankin
Rectum and Colon	53%	Lahey
Limited and no nodes	90%	Lahey
Larynx—cord only	80-85%	Tucker
Nasopharynx	31%	Stuart
Tongue, Tonsil and Gum	25%	Stuart

* Schmitz Classification of Cancer.
Classification I: Cancer localized to the cervix. Cervix freely movable.
Classification II: Cancer confined to the cervix, but uterus has impeded movability.
Reference: Classification of Uterine Cancer, *American Journal of Roentgenology*. 1920, Vol. 7, p. 383.

However, even in early cancer, the curability depends upon immediate diagnosis and prompt, adequate treatment. Any appreciable delay may deprive the patient of 50 per cent of his chance of cure. The period of delay between occurrence of symptoms and adequate treatment is the reason for much of our present mortality.

The lapse of time between the occurrence of initial symptoms and effective treatment (Table 2) is the most discouraging factor in the control of cancer today. This is particularly true in the case of carcinoma of the uterus. In a series of 235 cases at the Jefferson Hospital in Philadelphia, only 12 per cent were in Groups I and II of the Schmitz classification; that is, in a reasonably curable stage. The average duration of carcinoma of the rectum is 12.1 months (Newman), carcinoma of the cervix, 11 months (Macfarland), carcinoma of the breast, nine months (Haagensen).

TABLE 2.—*Duration of Symptoms in Carcinoma Patients Before Treatment*

	6 mo.	1 yr. or more	
Lung	50%		(Hollingsworth)
Body of the Uterus	50%	33%	(Corscaden)
Cervix	49%	28%	(Healy)

AVERAGE DURATION OF SYMPTOMS

Rectum	13.1 months	(Newman)
Cervix	11.0 months	(Macfarland)
Breast	35.4 weeks	(Haagensen)

The tragic note in this period of delay is the fact that most of it is unnecessary. It is largely due to the patient's ignorance, indifference, or fear. However, a significant part of the delay is ascribable to the attending physician. In 27 per cent of Haagensen's breast series at the Presbyterian Hospital in New York the patients said they had been seen by physicians and advised that the lesion was unimportant. In this group of cases the average delay was more than 18 months. Of a series of 83 cases at the Woman's Hospital in Philadelphia, Macfarland reports that in 23 per cent the responsibility for the delay rested upon the family physician. A more serious problem arises in carcinoma of the rectum. Graham reports a series of carcinomas of the rectum in which approximately 50 per cent of the patients received originally an incorrect diagnosis of bleeding piles or colitis. Jones reports from the Massachusetts General Hospital that over 75 per cent of the patients in whom carcinoma of the rectum was diagnosed had been previously treated for hemorrhoids.

The control of cancer mortality depends greatly on eliminating this period of unnecessary delay before treatment is begun. This can be accomplished by the education of the public and the education of the family physician. The program of lay education has advanced well in the last ten years through the publicity of the American Cancer Society, national insurance companies and Public Health agencies. The professional education of the physician has progressed more slowly and is probably the more important of the two. So important is this field of professional education that *one of the national medical societies is urging that all or most of the available federal funds be spent for education of the medical*

profession. Dr. Haagensen stated at the Nineteenth Graduate Fortnight of the New York Academy of Medicine that "For the present our best immediate hope of progress in our attack on cancer is better education of physicians in the use of proved diagnostic methods."

Professional education should be directed both to the importance of detecting early cancer and to the methods of early diagnosis. The physician in general practice sees relatively few cancer patients each year. Often he is not equipped to treat cancer cases. Because of these facts it is difficult to maintain his interest. However, the fate of the cancer patient lies in his hands. Most cancer patients are first seen by their family physician and accept his advice, and this entails a heavy moral responsibility. The private physician can ill afford to overlook early cancer or to delay in attempting to make a prompt diagnosis, or in obtaining adequate treatment for his patient. Education should be directed to the importance of a thorough examination, including biopsy in all suspicious lesions. The physician should suspect cancer in every patient over 40 years of age and should eliminate the possibility of cancer as a cause of presenting symptoms or as a latent lesion. He should be taught that reassurance of a patient or prescription without adequate examination may deprive a cancer patient of 50 per cent of his chance of cure. The physician should be taught the danger of metastases during any delay to "wait and see."

The physician should know what is adequate treatment for cancer. He should know that temporizing with any suspicious lesion may often condemn a patient to an untimely death. He should be taught that superficial cauterization of a skin cancer or a lesion of the cervix without biopsy, treatment of hemorrhoids without a rectal examination, fulguration of a black mole, are never justifiable.

The physician should also be encouraged to realize his personal limitations. Recognition of the lesion may save the patient's life, but if the physician is uncertain about the diagnosis or has not the facilities to arrive at a diagnosis, he should protect his patient and himself by seeking immediate consultation. If the physician has not the facilities or the training to give adequate treatment, he should direct his patient immediately to others who are competent to do so.

The physician in general practice, with careful examination and biopsy, can recognize at least 75 per cent of accessible cancers. If he is cancer-conscious and makes a practice of thoroughly examining suspicious lesions and demands an immediate decision, if he seeks consultations whenever he is in doubt, if he demands adequate treatment of his cancer patients, he can save many lives and prevent untold suffering.

There are five ways in which the practicing physician who is cancer-conscious can play a decisive role in cancer control:

1. By insisting in his own practice on an immediate diagnosis, frequently by biopsy, of every suspicious lesion and by demanding immediate adequate treatment.
2. By insisting on a complete physical examination of his patients over 40 years of age to determine whether or not they have cancer in addition to the lesion for which they are being treated. Too frequently the patient develops a carcinoma of the breast or cervix while under treatment for some unrelated condition.
3. By making a practice of periodic physical examinations to detect early cancer in his own patients. The nationwide publicity of the American Cancer Society is educating the public to expect periodic examinations for the early detection of cancer. Cancer Detection Centers will always cover only a small percentage of the population, and the privilege of cancer detection will always fall to the private physician if he will accept it. Periodic physical examination has been the policy of the American Medical Association for 20 years and the Cancer Commission of the California Medical Association urged this procedure in 1932 as the most effective way of discovering early lesions. *The physician in private practice can best educate his patients to the need of periodic check-up, and these examinations can be performed better in his own private office than elsewhere.* For this reason the Cancer Commission has developed and mailed to every member of the California Medical Association a periodic examination sheet, the use of which would greatly aid in noting early signs and symptoms of cancer. Additional copies of these blanks may be obtained from the office of your State Association.
4. By accepting cases that are referred to him by the county medical society, the American Cancer Society, or public health agencies for examination, diagnosis, or treatment. One of the present difficulties of the public health nurses and volunteer agencies is in not knowing to whom they may send patients with suspicious symptoms with assurance they will be sympathetically received and given a complete physical examination. Each county medical society should have a list of its members who are willing to accept and examine potential cancer patients and it should be prepared to refer inquirers promptly for intelligent medical advice.
5. By educating his own patients in the facts and danger signals of cancer. *Every physician's office should be a cancer information center.* The physician should respect the fear and anxiety of any patient who comes to him inquiring about cancer and he should take the problem seriously. The patient should be led to feel that he can come to his own doctor with intelligent questions or suspicions about cancer and receive an intelligent, sympathetic answer. Very few of these inquirers will be neurotics with cancerophobia. The patient should not feel that he is imposing upon his physician by asking for a periodic

physical examination, but he should be encouraged to come for an annual check-up and to bring to his physician his questions about cancer and his personal problems. Frequently patients will go to a Public Health agency because they feel that their own physician is not interested or would not give them the time for consultation and examination when they have no symptoms or when they are not really sick. The patient will receive lay education from magazines, the radio, and Public Health agencies, but he should be able to take his own problems and fears and those of his family to his private physician and know that he will be given the personal information that he needs.

The physician is the logical source of information in the community. His patients, his associates and his friends will have confidence in his statements regarding the dangers of cancer and the need for immediate action. The voluntary public health agencies should be able to call upon the physician to help them in their educational program on the radio, in the public schools, in clubs and in community meetings, for *his* interest and advice will carry more weight in his community than that of any outside speaker or agency. The interest of the public in the cancer control program will be in direct proportion to the interest and activity of the physicians in their community.

Throughout the state the Cancer Commission is finding that the physician is fearful that the cancer control program will encroach upon the private practice of medicine. There is no foundation for such fear. No matter what facilities may be established, the family physician will continue to see the vast majority of cancer patients in the first instance when they are curable, and he and his colleagues will have the first chance of achieving cure. The family physician will continue to be the determining factor in eliminating the sometimes fatal and always unnecessary delay before adequate treatment. The program of cancer consultation centers and detection centers is so organized in California as to assist and not compete with the practicing physician. Tumor Boards are organized to aid when he needs consultation and his patients are then referred back to him. In the Detection Center the examinee who has suspicious symptoms or any evidence of disease is referred to his own physician for diagnosis and treatment, or he is referred to a physician under the direction of the county medical society. The information centers of the American Cancer Society refer all patients to a physician under a policy established by the county medical society. This program and policy will help the private physician to practice better medicine and will bring to his office patients who would not otherwise seek a physician while their disease is still curable.

The future program in the effective care of cancer patients is no different than the present procedure for the handling of other major diseases. The private physician who is practicing good medicine is continually seeking the advice and assistance of his specialist conferees in major surgical problems, difficult orthopedic cases, or obscure metabolic diseases. In so doing he does not lose his contact with or interest in the patient and he will not do so in the case of his cancer patient.

SUMMARY

The family physician who is cancer conscious is in the best position to find early cancer because the great majority of patients see their family physician first and will accept his direction and advice. Cancer detection by a periodic health examination must be obtained in the physician's office, since cancer detection centers can cover only a small part of the field. The most effective lay education can come from the physician in his contact with his patients and associates. The activities of the voluntary health agencies will receive public support in proportion to his interest and active participation. The program of cancer control will depend largely upon how effectively we can enlist his support. For these reasons the Cancer Commission believes that professional education of the private physician is the greatest immediate need in the Cancer Control Program.

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